MARYLAND HEALTH CARE COMMISSION

_____
MATTER/DOCKET NO.

_____
DATE DOCKETED

HOME HEALTH AGENCY
APPLICATION FOR CERTIFICATE OF NEED

ALL PAGES THROUGHOUT THE APPLICATION SHOULD BE NUMBERED CONSECUTIVELY.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1.a. _____
Legal Name of Project Applicant
(i.e. Licensee or Proposed Licensee)

b. _____
Street

c. _____
City State Zip

d. _____
Telephone No.

e. _____
Name of Owner/Chief Executive

2.a. _____
Legal Name of Project Co-Applicant
(i.e. if more than one applicant)

b. _____
Street

c. _____
City State Zip

d. _____
Telephone

e. _____
Name of Owner/Chief Executive

f. _____
Email

3.a. _____
Name of Facility

b. _____
Street (Project Site)

c. _____
City/State Zip County

4. _____
Name of Owner (if different than applicant)

5.a. _____
Representative of Co-Applicant

b. _____
Street

c. _____
City Zip County

d. _____
Telephone

e. _____
Email

6. Person(s) to whom questions regarding this application should be directed: (Attach sheets if additional persons are to be contacted)

a. _____ Name and Title	a._____ Name and Title
b. _____ Street	b._____ Street
c. _____ City State Zip	c._____ City State Zip
d. _____ Telephone No.	d._____ Telephone No.
e. _____ Fax No.	e._____ Fax No.
f. _____ Email	f._____ Email

7. Legal Structure of Licensee (Check ☑ from a, b, or c. If checking b or c, also indicate whether the entity exists or is yet to be formed.):

a.	Governmental	___				
b.	Nonprofit Corporation	___	Existing	___	To be Formed	___
c.	Proprietary	___	Existing	___	To be Formed	___
	i. Sole Proprietorship	___				
	ii. Partnership	___				
	iii. Limited Liability Corp.	___				
	iv. Subchapter "S" Corp.	___				
	v. Other	___				
	(Please specify.) _____					

8. Agency Type: ☑

a. Health Department	___
b. Hospital-Based	___
c. Nursing Home-Based	___
d. Continuing Care Retirement Community-Based	___
e. HMO-Based	___
f. Freestanding	___
g. Other	___
(Please Specify.) _____	

9. Agency Service Type: ☑

DEFINITIONS FOR QUESTION 9: A *general home health agency* means a home health agency that provides a full range of home health services that are not restricted as a specialty home health agency. A *specialty home health agency* means a home health agency that provides: (1) Services exclusively to the pediatric population; (2) An array of services exclusively to a population group limited by the nature of its diagnosis or medical condition; (3) To all population groups, a highly limited set of services that can offer acceptable quality only through specialized training of staff and an adequate volume of experience to maintain specialized skills; or (4) Services exclusively to the residents of a specific continuing care retirement community.

a. General Home Health Agency ___
b. Specialty Home Health Agency ___

10. Agency Services (Please check ☑ all applicable.)

Service	Currently Provided in Maryland		Proposed to be Provided in the Target Jurisdiction for this Application	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Routine/Skilled Nursing Services				
IV/Enteral/TPN				
Psychiatric				
Early Maternal Discharge/Well Newborn				
Antepartum Care/Fetal Monitoring				
Home Health Aide				
Occupational Therapy				
Speech, Language Therapy, Audiology				
Physical Therapy				
Medical Social Services				

Respiratory Therapy (by a Respiratory Therapist)				
Respite Care				
Homemaker/Chore				
Dietary/Nutritional Counseling (by a Nutritionist)				
Personal Care Services				
Telemedicine				
Sign Language Interpreter				
Foreign Language Interpreter				

11. Offices

Identify the address of all existing main office, subunit office, and branch office locations and identify the location (city and county) of all proposed main office, subunit office, and branch offices, as applicable.

Existing Main Office Address: (Street, City, County, State and Zip Code)

_____

Area Code and Telephone:_____

Existing Subunit Office Addresses: (Street, City, County, State and Zip Code)

_____

_____

Area Code and Telephone:_____

Existing Branch Office Addresses: (Street, City, County, State and Zip Code)

_____

_____

_____

Area Code and Telephone:_____

■■■■■

Proposed Main Office Location:

_____

Proposed Subunit Office Locations:

_____

_____

Proposed Branch Office Locations:

_____

_____

_____

12. Project Implementation Target Dates

(INSTRUCTION: IN COMPLETING ITEM 12, PLEASE NOTE THAT COMMISSION REGULATIONS AT COMAR 10.24.01.12 STATE THAT "HOME HEALTH AGENCIES HAVE UP TO 18 MONTHS FROM THE DATE OF THE CERTIFICATE OF NEED TO: (i) BECOME LICENSED AND, IF APPLICABLE, MEDICARE CERTIFIED; AND (ii) BEGIN OPERATIONS IN THE JURISDICTION FOR WHICH THE CERTIFICATE OF NEED WAS GRANTED.")

A. Licensure: _____months from CON approval date.
B. Medicare Certification _____months from CON approval date.

13. Project Description:

Provide a summary description of the project, including all of the types of home health agency services to be established, expanded, or otherwise affected if the project receives approval. Please attach this description as a separate sheet or section to your application.

PART II - PROJECT BUDGET

INSTRUCTION: All estimates for 1.a.- c., 2.a.- j., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. (DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. Use of Funds

1. Capital Costs:

a.	New Construction	$ _____
(1)	Building	_____
(2)	Fixed Equipment (not included in construction)	_____
(3)	Land Purchase	_____
(4)	Site Preparation	_____
(5)	Architect/Engineering Fees	_____
(6)	Permits, (Building, Utilities, Etc.)	_____
SUBTOTAL		$ _____
b.	Renovations	
(1)	Building	$ _____
(2)	Fixed Equipment (not included in construction)	_____
(3)	Architect/Engineering Fees	_____
(4)	Permits, (Building, Utilities, Etc.)	_____
SUBTOTAL		$ _____
c.	Other Capital Costs	
(1)	Major Movable Equipment	_____
(2)	Minor Movable Equipment	_____
(3)	Contingencies	_____
(4)	Other (Specify)	_____
TOTAL CURRENT CAPITAL COSTS (a - c)		$ _____
d.	Non-Current Capital Cost	
(1)	Interest (Gross)	$ _____
(2)	Inflation (state all assumptions, Including time period and rate)	$ _____
TOTAL PROPOSED CAPITAL COSTS (a - d)		$ _____

2. Financing Cost and Other Cash Requirements:

a.	Loan Placement Fees	$ _____
b.	Bond Discount	_____
c.	Legal Fees (CON Related)	_____
d.	Legal Fees (Other)	_____
e.	Printing	_____
f.	Consultant Fees	
	CON Application Assistance	_____
	Other (Specify)	_____
g.	Liquidation of Existing Debt	_____
h.	Debt Service Reserve Fund	_____
i.	Principal Amortization Reserve Fund	_____
j.	Other (Specify)	_____
	TOTAL (a - j)	$ _____

3. Working Capital Startup Costs $ _____

TOTAL USES OF FUNDS (1 - 3) $ _____

B. Sources of Funds for Project:

1.	Cash	_____
2.	Pledges: Gross _____, less allowance for uncollectables _____ = Net	_____
3.	Gifts, bequests	_____
4.	Interest income (gross)	_____
5.	Authorized Bonds	_____
6.	Mortgage	_____
7.	Working capital loans	_____
8.	Grants or Appropriation	
	(a) Federal	_____
	(b) State	_____
	(c) Local	_____
9.	Other (Specify)	_____

TOTAL SOURCES OF FUNDS (1-9) $ _____

Lease Costs:

a. Land	$_____	x _____	= $_____
b. Building	$_____	x _____	= $_____
c. Major Movable Equipment	$_____	x _____	= $_____
d. Minor Movable Equipment	$_____	x _____	= $_____
e. Other (Specify)	$_____	x _____	= $_____

PART III - CONSISTENCY WITH REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

(INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G. Each criterion is listed below.)

10.24.01.08G(3)(a). "The State Health Plan" Review Criterion

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

The following standards must be addressed by all home health agency CON applicants, as applicable. Provide a direct, concise response explaining the proposed project's consistency with each standard. In cases where standards require specific documentation, please include the documentation as a part of the application.

GENERAL HOME HEALTH AGENCY STANDARDS

COMAR 10.24.08.10A(1), Service Area

An applicant shall: (a) Designate the jurisdiction in which it proposes to provide services; and (b) When applying to provide services in more than one jurisdiction, provide an overall description of the configuration of the parent home health agency and its interrelationships, including the designation and location of its main office, each subunit, and each branch, as defined in this Regulation, or other major administrative offices recognized by Medicare.

COMAR 10.24.08.10A(2), Financial Accessibility

(a) An applicant shall be, or proposed to be, Medicare- and Medicaid-certified, and accept clients whose expected primary source of payment is one or both of these programs.
(b) An applicant seeking Certificate of Need approval as a specialty home health agency may show evidence why this rule should not apply.

COMAR 10.24.08.10A(3), Information to Providers and the General Public

(a) An applicant shall inform the following entities about the agency's services, service area, reimbursement policy, office locations, and telephone numbers:
    i) Except as provided in .10B(5) of this Chapter, all hospitals, nursing homes, assisted living facilities, and hospice programs within its proposed service area;
    ii) At least five physicians who practice in its proposed service area;
    iii) At least one appropriately age-focused Medicaid home and community-based waiver program;
    iv) Except as provided in .10B(5) of this Chapter, the Senior Information and Assistance offices located in its proposed service area; and
    v) The general public in its proposed service area.
(b) An applicant shall make its fees known to clients and their families before services are begun.

COMAR 10.24.08.10A(4), Time Payment Plan

An applicant shall: (a) Establish special time payment plans for an individual who is unable to make full payments at the time services are rendered; and (b) Submit to the Commission and to each client a written copy of its policy detailing time payment options and mechanisms for clients to arrange for time payment.

COMAR 10.24.08.10A(5), Charity Care and Sliding Fee Scale

Each applicant for home health agency services shall have a written policy for the provision of charity care for uninsured and underinsured patients to promote access to home health agency services regardless of an individual's ability to pay.

(a) The policy shall include provisions for, at a minimum, the following:
    i) Establishing estimates of the amount of charity care the agency intends to provide annually;
    ii) A sliding fee scale for clients unable to bear the full cost of services;
    iii) Individual notice of its charity care and sliding fee scale policies to each client before services are begun; and
    iv) Making a determination of probable eligibility for charity care and/or reduced fees within two business days of the client's initial request.

(b) An applicant for a specialty home health agency exclusively serving continuing care retirement community residents may present evidence why .10A(5)(a) of this Regulation should not apply.

COMAR 10.24.08.10A(6), Quality

An applicant shall develop an ongoing quality assurance program that includes compliance with all applicable federal and state quality of care standards, and provide a copy of its program protocols when it requests first time approval as required by COMAR 10.24.01.18.

COMAR 10.24.08.10A(7), Cost

An applicant shall assure that its costs and charges are not excessive in relation to those of other agencies that operate in the same and nearby jurisdictions.

COMAR 10.24.08.10A(8), Linkages with Other Service Providers

Except as provided in .10B(5) of this Chapter, an applicant shall document its established links with hospitals, nursing homes, hospice programs, assisted living providers, Adult Evaluation and Review Services, Senior Information and Assistance, adult day care programs, the local Department of Social Services, and home-delivered meal programs located within its proposed service area.

(a) A new home health agency shall provide this documentation when it requests first use approval.

(b) A home health agency already licensed and operating in Maryland shall provide documentation of these linkages before beginning operation in the new jurisdiction.

COMAR 10.24.08.10A(9), Discharge Planning

An applicant shall provide documentation of a formal discharge planning process.

COMAR 10.24.08.10A(10), Financial Solvency

An applicant shall document that it can comply with the capital reserve and other solvency requirements specified by the Centers for Medicare and Medicaid Services (CMS) for a Medicare-certified home health agency.

COMAR 10.24.08.10A(11), Data Collection and Submission

An applicant shall demonstrate the ability to comply with all applicable federal and State data collection requirements including, but not limited to, the Commission's Home Health Agency Annual Report and the CMS's Outcome and Assessment Information Set (OASIS).

SPECIALTY HOME HEALTH AGENCY STANDARDS

COMAR 10.24.08.10B(1), Need

An applicant shall demonstrate quantitatively that there exists an unmet need that it intends to address. This demonstration shall include but not be limited to:

(a) Identification of the characteristics and/or special needs of the client group to be served;
(b) A detailed description of the types and quantities of specialty home health care services that the client group needs or is projected to need; and
(c) An assessment of the extent to which the home health needs of the client group are or are not being met by existing home health service providers.

COMAR 10.24.08.10B(2), Quality

(a) An applicant shall demonstrate that its program will be more effective in meeting its clients' needs than those programs provided by existing home health agencies in its proposed service area.
(b) An applicant shall demonstrate that it will be able to provide appropriate referrals to maintain continuity of care.

COMAR 10.24.08.10B(3), System Cost

An applicant shall demonstrate how its program will reduce health care costs in other parts of the health care system.

COMAR 10.24.08.10B(4), Adding Populations or Services

An existing specialty home health agency that wishes to serve an additional population, or to provide services other than those described in its existing Certificate of Need, shall apply for another Certificate of Need.

COMAR 10.24.08.10B(5), Information to Providers and the General Public

Specialty home health agencies that do not serve persons over the age of 65 are not required to address .10A(3)(a)(iv) or those applicable portions of .10A(3)(a)(i), and .10A(8) of this Chapter that apply to populations of older adults.

COMAR 10.24.08.10B(6), Continuing Care Retirement Communities

(a) A continuing care retirement community (CCRC) proposing to establish a specialty home health agency to provide home health agency services to a specified CCRC shall:
    i) Serve exclusively the subscribers of the specified CCRC, who have executed continuing care agreements for the purpose of utilizing independent living units or assisted living beds within the continuing care facility, except as provided in COMAR 10.24.01.03K;
    ii) Permit subscribers of the CCRC to receive these services from other home health agencies authorized by the Commission to provide services in the same jurisdiction; and
    iii) Provide to the subscribers of the CCRC a list of home health agencies authorized by the Commission to provide services in the same jurisdiction, and provide a copy of this list when it requests first-use approval.
(b) If a CCRC served by a Certificate of Need-approved specialty home health agency with which it has an exclusive contractual agreement chooses to terminate that contract:
    i) The specialty home health agency's authority to provide these services to subscribers of the CCRC is also terminated; and

ii) Any entity with which the CCRC may subsequently seek an exclusive contractual agreement to provide home health agency services to its subscribers must obtain a Certificate of Need as a specialty home health agency in its own right.

10.24.01.08G(3)(b). The "Need" Review Criterion

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

Please discuss the need of the population served or to be served by the Project. Recognizing that the State Health Plan has identified a sufficient level of "net need" to establish an opportunity for review of CON applications in the target jurisdiction, applicants are expected to provide a quantitative analysis that, at a minimum, describes the Project's expected service area; population size, characteristics, and projected growth; and, projected home health services utilization.

[(INSTRUCTION: All applicants should complete Table 2. If the applicant is an existing home health agency, also complete Table 1, showing historic and projected utilization for all home health agency services provided in Maryland and complete Table 2 for the proposed project, showing projected utilization only for the jurisdiction which is the subject of the application. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). Both tables should report an unduplicated count of clients.]

TABLE 1: STATISTICAL PROJECTIONS –HISTORIC AND PROJECTED HOME HEALTH AGENCY SERVICES IN MARYLAND

	Two Most Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__	20__	20__	20__
1. Client Visits							
a. Billable							
b. Non-Billable							
c. TOTAL							

TABLE 1 (CONT.)	Two Most Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__	20__	20__	20__
2. No. of Clients and Visits by Discipline							
a. Total Clients (Unduplicated Count)							
b. Skilled Nursing Visits							
c. Home Health Aide Visits							
d. Physical Therapy Visits							
e. Occupational Therapy Visits							
f. Speech Therapy Visits							
g. Medical Social Services Visits							
h. Other Visits (Please Specify)							

TABLE 2: <u>STATISTICAL PROJECTIONS - PROJECTED HOME HEALTH AGENCY SERVICES IN THE TARGET JURISDICTION</u>
(See Instructions preceding Table 1.)

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__
1. Client Visits				
a. Billable				
b. Non-Billable				
c. TOTAL				

	Projected Years (ending with first full year at full utilization)			
	20__	20__	20__	20__
2. No. of Clients and Visits by Discipline				
a. Total Clients (Unduplicated Count)				

Table 2 (cont.)	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__
b. Skilled Nursing Visits				
c. Home Health Aide Visits				
d. Physical Therapy Visits				
e. Occupational Therapy Visits				
f. Speech Therapy Visits				
g. Medical Social Services Visits				
h. Other Visits (Please Specify)				

10.24.01.08G(3)(c). The "Availability of More Cost-Effective Alternatives" Review Criterion

The Commission shall compare the cost-effectiveness of the proposed project with the cost-effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Please explain the characteristics of the Project which demonstrate why it is a less costly and/or a more effective alternative for meeting the needs identified than other types of projects or approaches that could be developed for meeting those same needs or most of the needs.

A clear statement of project objectives should be outlined. Alternative approaches to meeting these objectives should be fully described. The effectiveness of each alternative in meeting the project objectives should be evaluated and the cost of each alternative should be estimated.

For applications proposing to demonstrate superior patient care effectiveness, please describe the characteristics of the Project that will assure the quality of care to be provided. These may include, but are not limited to: meeting accreditation standards, personnel qualifications of caregivers, special relationships with public agencies for patient care services affected by the Project, the development of community-based services or other characteristics the Commission should take into account.

10.24.01.08G(3)(d). The "Viability of the Proposal" Review Criterion.

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project

within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Please include in your response:

a. Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. The availability of each source of funds listed in Part II, B. Sources of Funds for Project, must be documented.

b. Existing home health agencies shall provide an analysis of the probable impact of the project on the costs and charges for services provided by your home health agency.

c. A discussion of the probable impact of the project on the cost and charges for similar services provided by other home health agencies in the area.

d. All applicants shall provide a detailed list of proposed patient charges for affected services.

TABLE 3: REVENUES AND EXPENSES – HISTORIC AND PROJECTED HOME HEALTH AGENCY SERVICES IN MARYLAND

(INSTRUCTIONS: All applicants should complete Table 4. If the applicant is an existing home health agency, also complete Table 3, showing historic and projected revenues and expenses for all home health agency services provided in Maryland and complete Table 4 for the proposed project, showing projected revenues and expenses only for the jurisdiction which is the subject of the application. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)] All projected revenue and expense figures should be presented in current dollars. Medicaid revenues for all years should be calculated on the basis of Medicaid rates and ceilings in effect at the time of submission of this application. Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses.)

TABLE 3	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__	20__	20__	20__
1. Revenue							
a. Gross Patient Service Revenue							
b. Allowance for Bad Debt							
c. Contractual Allowance							
d. Charity Care							
e. Net Patient Services Revenue							
f. Other Operating Revenues (Specify)							
g. Net Operating Revenue							

Table 3 (Cont.)	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__	20__	20__	20__
2. Expenses							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)							
b. Contractual Services (Please Specify)							
i.							
ii.							
iii.							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation							
g. Current Amortization							
h. Project Amortization							
i. Supplies							
j. Other Expenses (Specify)							
k. Total Operating Expenses							
3. Income							
a. Income from Operation							
b. Non-Operating Income							
c. Subtotal							
d. Income Taxes							
e. Net Income (Loss)							

Table 3 (Cont.)	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__	20__	20__	20__
4. Payor Mix: A. Percent of Total Revenue							
1. Medicare							
2. Medicaid							
3. Blue Cross							
4. Commercial Insurance							
5. Self-Pay							
6. Other (Specify)							
7. TOTAL REVENUE	100%	100%	100%	100%	100%	100%	100%
B. Percent of Total Visits							
1. Medicare							
2. Medicaid							
3. Blue Cross							
4. Commercial Insurance							
5. Self-Pay							
6. Other (Specify)							
7. TOTAL VISITS	100%	100%	100%	100%	100%	100%	100%

TABLE 4: REVENUES AND EXPENSES – PROJECTED HOME HEALTH AGENCY SERVICES FOR TARGET JURISDICTION

(See previous Instructions concerning Tables 3 and 4.)

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__
1. Revenues				
a. Gross Patient Services Revenue				
b. Allowance for Bad Debt				
c. Contractual Allowance				
d. Charity Care				
e. Net Patient Care Service Revenues				
f. Total Net Operating Revenue				
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)				
b. Contractual Services (Please Specify)				
i.				
ii.				
iii.				
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation				
f. Project Depreciation				
g. Current Amortization				
h. Project Amortization				
i. Supplies				
j. Other Expenses (Specify)				
k. Total Operating Expenses				

Table 4 (Cont.)	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__
3. Income				
a. Income from Operation				
b. Non-Operating Income				
c. Subtotal				
d. Income Taxes				
e. Net Income (Loss)				
4. Payor Mix: A. Percent of Total Revenue				
1. Medicare				
2. Medicaid				
3. Blue Cross				
4. Commercial Insurance				
5. Self-Pay				
6. Other (Specify)				
7. TOTAL REVENUE	100%	100%	100%	100%
B. Percent of Total Visits				
1. Medicare				
2. Medicaid				
3. Blue Cross				
4. Commercial Insurance				
5. Self-Pay				
6. Other (Specify)				
7. TOTAL VISITS	100%	100%	100%	100%

10.24.01.08G(3)(e). The "Compliance with Conditions of Previous Certificates of Need" Review Criterion.

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

List all prior Certificates of Need that have been issued since 1990 to the project applicant or to any entity which included, as principals, persons with ownership or control interest in the project applicant. Identify the terms and conditions, if any, associated with these CON approvals and any commitments made that earned preferences in obtaining any of the CON approvals. Report on the status of the approved projects, compliance with terms and conditions of the CON approvals and commitments made.

10.24.01.08G(3)(f). The "Impact on Existing Providers" Review Criterion.

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

Indicate the positive impact on the health care system of the project, and why the project does not duplicate existing health care resources. Describe any special attributes of the project that will demonstrate why the project will have a positive impact on the existing health care system.

Please provide:

1. An assessment of the sources available for recruiting additional personnel;

2. A description of your plans for recruitment and retention of those personnel believed to be in short supply;

3. For existing home health agencies, a report on average vacancy rate and turnover rates for affected positions in the last year.

4. Complete Table 5.

TABLE 5. MANPOWER INFORMATION

(INSTRUCTION: List by service the staffing changes (specifying additions and/or deletions and distinguishing between agency employee and contractual services required by this project. The number of FTEs should be calculated on the basis of 2,080 paid hours per year equals one FTE. Indicate any factor used in converting paid hours to worked hours.

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel								
Registered Nurse								
Licensed Practical Nurse								
Physical Therapist								
Occupational Therapist								
Speech Therapist								
Home Health Aide								
Medical Social Worker								
Other (Please specify.)								
						Benefits		
						TOTAL		

5. Indicate the method used in calculating the benefits expense shown in Table 5.

PART IV - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY,

AUTHORIZATION AND SIGNATURE

1. List the name and address of each owner or other person responsible for the proposed project and its implementation. If the applicant is not a natural person, provide the date the entity was formed, the business address of the entity, the identify and percentage of ownership of all persons having an ownership interest in the entity, and the identification of all entities owned or controlled by each such person.

_____
_____
_____
_____
_____

2. Is the applicant, or any person listed above now involved, or ever been involved, in the ownership, development, or management of another health care facility or program? If yes, provide a listing of each facility or program, including facility name, address, and dates of involvement.

_____
_____
_____
_____

3. Has the Maryland license or certification of the applicant home health agency, or any of the facilities or programs listed in response to Questions 1 and 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owner or other person responsible for implementation of the Project was not involved with the facility or program at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

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4. Is any facility or program with which the applicant is involved, or has any facility or program with which the applicant or other person or entity listed in Questions 1 & 2, above, ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to an action to suspend, revoke or limit the licensure or certification at any facility or program. If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility or program, and any final disposition reached by the applicable governmental authority.

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5. Has the applicant, or other person listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense connected in any way with the ownership, development or management of the applicant facility or program or any health care facility or program listed in response to Question 1 & 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

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One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or authorized agent of the applicant for the proposed home healthy agency service.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

_____ _____

Date Signature of Owner or
Authorized Agent of the Applicant